STATE OF MONTANA DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES

APPLICATION FOR FULL CERTIFICATION AS A MENTAL HEALTH PROFESSIONAL PERSON

	PART III - REFERENCES
qualifi name : forms	HE APPLICANT: The Certification Committee requires that three people who can comment on your cations as a mental health professional person provide the information requested. Type or print your and the name of a person who is able to comment on your qualifications on each form. The completed should be sent directly to the Certification Committee by the recommender. A seperate form is required for each reference.
	Name of Applicant
Dear	: Recommender
certifi	ave been requested to provide information regarding the above-named applicant's qualifications to be ed as a mental health professional person by the State of Montana. Please answer each of the questions as completely as you can.
1.	How long have you known this applicant?
2.	Describe your professional relationship with the applicant.
3.	During the course of your professional relationship, how often do (did) you have contact with the applicant?

Nam	Name of Applicant:			
4.	Have you read reports this applicant has written concerning the mental status and treatment needs of mentally ill persons? If yes, please comment on the applicant's skill in these areas.			
5.	To your knowledge, has this applicant had experience evaluating persons who are seriously mentally ill? If yes, please comment on the nature and extent of this experience.			
6.	To your knowledge, has this applicant had experience treating persons who are seriously mentally ill? If yes, please comment on the nature and extent of this experience.			

Name	of Applicant:
7.	Have you had the opportunity to observe this applicant taking part in professional meetings during which a client's treatment plan was developed or reviewed? If yes, please comment on the nature and extent of the applicant's contribution to the discussion.
8.	In your opinion, is this applicant knowledgeable regarding the full range of mental health services throughout Montana?
9.	What evidence, if any, have you observed regarding this applicant's knowledge and understanding of the laws, regulations, and policies which pertain to the rights of the mentally ill in Montana?
10.	Do you recommend that this applicant be certified as a mental health professional? Yes No Not Sure

Name	of Applicant: _	
11.	Other Commer	nts (Optional):
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	-	
regard gives t approv institut	ing this applicant o mental health pe ve voluntary adm	I have given to the above questions represent my best and most complete knowledge 's qualifications to be mental health professional person. I understand that Montana law professional persons a number of important responsibilities, including the authority to hissions to mental health facilities, provide expert testimony regarding the need for ommitment hearings, and to develop and supervise treatment plans of individuals in facilities.
Signat	ure:	Date:
Printed	d Name:	
Positio	onn:	
Work	Address:	
Retur	n this form to:	Professional Person Certification Committee Addictive & Mental Disorders Division

Helena, MT 59620-2905

P.O. Box 202905